STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968942	**07/03/2017**
NAME OF PROVIDER OR SUPPLIER **THE FOUNTAINS OF HOPE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2250 JESUS WAY** **SARASOTA, FL 34240**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint survey for CCR# 2017005696 was completed on at The Fountains of Hope, an assisted living facility (license #12784) in Bonita Springs, Florida.

The complaint contained 3 allegations, of which 1 was substantiated.

The following is description of the deficiency.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on review of facility policies, and procedures and resident and staff interviews, the facility failed to ensure residents were free from for 3 (Resident #1, #2, and #3) of 6 residents sampled. The facility failed to identify possible and intervene during an investigation.

The findings included:

Review of the facility's policy dated revealed:
"(3a) Associate : any associate who witnesses or becomes aware of alleged , neglect or , should report such incident to the ED [Executive Director] or supervisor on duty immediately.
(4a) Response to Incident - Protection of Resident, upon learning of alleged , neglect or , the ED or supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of , neglect or , while a determination on the matter is pending."

On at 10:30 a.m., Certified Nursing Assistant (CNA) Staff E said she witnessed CNA Staff A act in an manner toward residents, in , to Resident #3, when the resident was singing. CNA Staff E said CNA Staff A stuck her finger in Resident #3's face and with clenched told her she had to stop singing. Staff E said Staff A spoke in an angry voice. Staff E said one time she observed Resident #1 get up from the table and with clenched CNA Staff A told him in his face, no, you can't go, you have to sit here and eat (pointing to a seat).

During an interview on at 12:20 p.m., Resident #1 said CNA Staff A had spoken to him with her clenched. Resident #1 said he thought Staff A was mad at him. He said CNA Staff A told him he cannot leave the table. He said he does not like that. He wants to leave when he wants to.

During an interview on at 12:12 p.m., Resident Assistant ( ) Staff H stated she has seen CNA

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Staff A "act in a mean way." Staff H said earlier today, she was trying to put Resident #2's feet up. Staff H stated, "[CNA Staff A] came over, grabbed him by the face and angrily told him with clenched , his feet needed to go up." Staff H said at first she thought CNA Staff A might have been trying to get Resident #2 to look at her, but said CNA Staff A should not have grabbed his face to do it. Staff H said she has seen CNA Staff A talk to other residents by talking through clenched . She said she does not think CNA Staff A should do this. She said she has had training and the hotline number is posted in the break . She said she did not think to report CNA Staff A.

During an interview on at 12:30 p.m., the Director of the Memory Care Unit and the Executive Director (ED) acknowledged they allowed CNA Staff A to remain working on the Memory Unit (Hopes Place) as the investigation was going on.

Class III